MEDICAL ASSISTANCE ELIGIBILITY

Overview

July 2012

Washington State Health Care Authority
Medicaid Program

NOTE: These are guidelines only. The Health Care Authority (HCA) has final responsibility for eligibility for medical benefits.

HCA 22-315 (6/12)

Table of Contents

This information is also available on the Medicaid website at
http://hrsa.dshs.wa.gov/pdf/Publications/22_315.pdf

Washington State Health Care Authority

Introduction

This guide offers an overview of eligibility requirements for medical programs. It doesn't include all requirements or consider all situations that may arise. Please contact your local Community Services (CSO) or Home and Community Services (HCS) Office for information about specific situations.

Income levels (such as those based on Federal Poverty Level (FPL), Cost of Living Adjustments (COLA), and specific program standards) change yearly, but in different months. We update the guide yearly to reflect standard and program changes. Please understand that, while the information in this publication is current at the time of publication, some of those standards will change before the next publication date.

We list each program's identifier after each program name on the following pages.

During the legislative session each year, some covered medical services may change. See the Scope of Care section of this publication to see the benefit packages/covered medical services for each program at the time of this publication.

Definitions

Health Care Authority:

The single state agency responsible for providing access to medical care for Washington's most vulnerable residents. The Medicaid program became part of the Health Care Authority effective July 1, 2011.

Categorically Needy (CN scope of care):

Federally matched Medicaid CN (Title XIX) and CHIP (Title XXI) programs provide the broadest scope of medical coverage. Persons may be eligible for CN only, or may **also** be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. Children ineligible for CN due to their family income may be eligible for the CHIP (Title XXI) medical program, which has the same scope of care as CN. CN includes full scope of coverage for pregnant women, children, the aged, blind, and persons with disabilities.

Federal Poverty Level (FPL):

A guideline for determining governmental program eligibility based on the Consumer Price Index guide from the year just completed. Some medical program eligibility limits are based on a percentage of the FPL.

Fee-For-Service:

The term used when a client is able to get care from doctors and other medical providers who will accept the client Services Card, without membership in a managed care organization or health maintenance organization.

Healthy Options:

Washington State Medicaid's managed care program.

Managed Care:

A prepaid comprehensive system of medical and health care services provided through a designated health care plan that contracts with Medicaid.

Medicaid:

The federally matched medical aid programs under Title XIX of the Social Security Act that cover the Categorically Needy (CN) and Medically Needy (MN) programs.

Medical Care Services (MCS):

The state-funded medical program that provides limited medical benefits to incapacitated eligible adults and to those eligible for the Alcohol and Drug Addiction and Treatment and Support Act program (ADATSA). Income and resource limits are more restrictive than for the family CN medical program. MCS does not cover out-of-state medical care.

Medically Needy (MN):

The federally matched Medicaid Program for the aged, blind, or persons with disabilities, as well as pregnant women, children, and refugees with income and/or resources above the CN limits. It provides slightly less medical coverage than CN.

TANF:

The Temporary Assistance for Needy Families program, which offers cash and other benefits to families in need.

Workfirst:

Washington State's Welfare to Work program under federal TANF legislation. It replaced the former Aid to Families with Dependent Children (AFDC) program in the 1990s.

Family Programs

TANF (Temporary Assistance for Needy Families (F01) and Family Medical Program

These programs provide aid to children and the adults who care for them. Families with eligible dependent children under the age of 19, whose net income and countable resources are below TANF limits may receive both TANF cash benefits and CN medical. TANF cash benefits are restricted to 60 months maximum in a lifetime. Family medical benefits do not have a maximum time limit.

A family may choose to receive only CN medical (Family medical, F04) and save their TANF eligibility for the future.

In determining net income, we deduct 50% of the family's earnings, actual childcare costs, and court-ordered child support paid out by the family.

For medical eligibility, a family with children may have $1,000 in resources at the time of application. Once the family is eligible, there is no resource limit while the family continues to receive only medical assistance.

Income Limits
Family Medical Program (F04)

Effective since 02/01/2011

Number of People	Monthly Income Limit
1	$359
2	$453
3	$562
4	$661
5	$762
6	$866
7	$1000
8	$1107

Special Situations:

Clients who are **not** eligible for cash benefits **but are eligible** for medical coverage include:

- Persons who are not cooperating with WorkFirst activities;
- Teen parents who are not in an approved living situation or are not meeting school requirements;
- Persons who have reached the 60-month TANF cash benefit limit;
- Persons who have income over the standard for TANF cash, but under the standard for Family medical program.

Medical Extension Benefits (MEB) (F02, F03, F10):

There are three Medical Extension Benefit (MEB) programs, sometimes called Transitional Medical Assistance (TMA).

Families that become ineligible for TANF cash or family medical benefits due to increased:

1. Earned income, are eligible for up to 12 months extended CN medical benefits (F02). Adults must pay a monthly premium during the second six months of eligibility, if the family's countable income is over 100% of the FPL. American Indians/Alaska Natives and pregnant women are exempt from premium payments.
2. Child support received, are eligible for up to 4 months of extended CN medical benefits (F03).
3. Income early in their certification period may receive benefits from a one- or two-month certification period bridge program (F10). These families would be eligible for F02 if they met the federal requirements of having received medical benefits for at least 3 months out of the last 6 months. F10 bridges the gap, allowing the federal requirement to be met.

State Family Assistance (SFA):

SFA is the state-funded cash program for legal immigrant families who do not meet eligibility requirements for the federal TANF program due to citizenship or immigration status.

- Children receiving SFA are eligible for Apple Health for Kids Programs (see that section of this publication).
- Adults on SFA are encouraged to apply for the Washington Health Program by calling 1-800-660-9840.

Pregnancy, Women's Health, and Family Planning

Pregnancy Medical (P02):

There is no resource limit for the pregnant women's CN medical program. The income limit is 185 percent of the Federal Poverty Level (FPL). Pregnant women can be eligible at any time during pregnancy. Once eligible, women's eligibility continues throughout the pregnancy and postpartum period, regardless of changes in income. Women who apply for medical coverage after the baby's birth don't qualify for the postpartum extension, but may qualify for help paying costs relating to the baby's birth, if the application is received within three months after the month during which the child was born.

To determine the pregnant woman's family size, count the number of household members, adding one for each verified unborn child. EXAMPLE: A woman living alone, who verifies she is pregnant with twins, is considered a three-person family.

Effective April 1, 2012

Number of People	Monthly Income Limit
1	N/A
2	$2,333
3	$2,944
4	$3,554
5	$4,165
6	$4,775
7	$5,386
8	$5,996

Add $610 for each additional household member

** Pregnant women with income above 185% FPL may be eligible for the MN program.*

Non-Citizen Pregnant Women (P04):

Pregnant women are eligible for CN scope of care under the non-citizen pregnant women's program if they aren't eligible for Medicaid because of citizenship or immigration status. This includes undocumented pregnant women.

Postpartum Extension (no separate program identifier):

The postpartum extension provides full scope medical coverage for women who receive medical benefits at the time their pregnancy ends. This allows continued medical coverage through the end of the month in which the 60th day following the end of the pregnancy falls (e.g., pregnancy ends June 10, medical benefits continue through August 31). Women receive this extension regardless of how the pregnancy ends.

Medically Needy Pregnant Women (P99):

Pregnant women with income over 185% FPL may be eligible for Medically Needy (MN) benefits after incurring medical costs equal to the amount of family income that is above the MN standard. To be eligible, women must also meet the Medically Needy resource standard. For more explanation of Medically Needy benefits, please see that section of this publication.

Family Planning Extension (P05):

The family planning extension provides an additional 10 months of medical coverage after pregnancy to citizen and qualified alien women for family planning services only. Women receive this extension regardless of how the pregnancy ends. The extension follows the postpartum coverage for eligible women who received medical benefits for the pregnancy.

Take Charge (P06):

This family planning program (for both men and women) began in July 2001. The program covers pre-pregnancy family planning services to help participants take charge of their lives and prevent unintended pregnancies. Both women and men may be eligible if family income is at or below 200 percent of FPL.

Coverage under TAKE CHARGE includes:

- Annual examination
- Family planning education and risk reduction counseling
- FDA-approved contraceptive methods including: birth control pills, IUDs, and emergency contraception
- Over the counter contraceptive products, such as condoms, and contraceptive creams and foams
- Sterilization procedures

Clients access services through local clinics, doctors' offices, and pharmacies that are participating in TAKE CHARGE. For information, call the toll-free Medicaid number @ 1-800-562-3022. Long waits are sometimes required, but self-service options are available.

Find additional information on the Medicaid website @: **http://hrsa.dshs.wa.gov/familyplan/**

Breast and Cervical Cancer Treatment Program (S30):

Medical coverage provided for women diagnosed with breast or cervical cancer or a related pre-cancerous condition, through the Department of Health's (DOH) Breast and Cervical Health Program (BCHP) or by the Breast and Cervical Early Detection program funded by the Centers for Disease Control. The DOH screening program establishes income and resource eligibility. Coverage continues throughout treatment for the condition.

A woman is eligible if she meets all of the following criteria:

- Is under age 65
- Has been screened by the BCHP or the CDC-funded program
- Requires treatment for breast or cervical cancer, or a pre-cancerous condition found through the screening
- Follows her treatment plan
- Doesn't have other insurance

For more information, see the Department of Health website @ **http://www.doh.wa.gov/cfh/bcchp/**

Apple Health for Kids Program

Funding for coverage under Apple Health for Kids may come through Title XIX (Medicaid), Title XXI (CHIP), or through state-funded programs. There are no resource limits for the Apple Health for Kids programs. Apple Health for Kids coverage is free to children in households with incomes of no more than 200% of the federal poverty level (FPL), and available on a premium basis to children in households with incomes of no more than 300% FPL.

Categorically Needy (CN) for newborns (F05):

A newborn is automatically eligible for 12 months of CN coverage if the mother received state medical benefits at the time of the child's birth, and the child is a Washington resident. There are no income or resource limits for this program.

Apple Health for Kids Programs (F06):

All Washington resident children under age 19, living in families whose income is at or below 200% FPL, have access to CN scope of care health coverage. Children ineligible for the Medicaid program due to citizenship or immigration issues receive the same scope of care funded by the state.

Premium-based Apple Health for Kids Programs (F07):

All uninsured Washington resident children under the age of 19 living in families with income between 200% and 300% FPL have access to CN scope of care in exchange for a monthly premium. Children ineligible for Federal funding under the program due to citizenship or immigration issues may still receive the same scope of care as those eligible for the federal/state program (CHIP), funded by the state.

Medically Needy Healthcare for Children (F99):

Children under age 19 in families with income over 300% FPL may be eligible for MN benefits after incurring medical costs equal to the amount of family income that is above the MN standard. For an explanation of Medically Needy benefits, please see that section of this publication.

Foster Care/Adoption Support (D01, D02):

Children receiving foster care or adoption support services may be eligible for CN medical benefits through this program. The child's foster care or adoption support caseworker manages this program.

Refugees

Refugees (R01, R02, R03):

The Refugee Assistance Program is a 100% federally funded program for persons granted asylum in the U.S. as refugees or asylees. Qualified individuals may receive cash benefits for a maximum of eight months and automatically receive Categorically Needy (CN) medical services. Immediately after entering the U.S., families and single refugees who meet income and resource standards are eligible for this program.

Eligibility for refugees/asylees that have been in the United States for more than eight months is determined the same as for U.S. citizens.

Special Immigrants:

Immigrants from Iraq and Afghanistan who were granted Special Immigrant status under section 101(a) (27) of the INA are eligible for TANF, Medicaid, Refugee Cash Assistance (RCA), and Refugee Medical Assistance (RMA) the same as refugees.

Aliens

Alien Emergency Medical Programs (AMP and AEM) (K03, L04, S07):

To be eligible for AMP a person must:

- Be categorically relatable to a Medicaid program (e.g., a parent with a dependent child, an adult with a disability, a blind or aged (65 or older) adult, or a child under age 19), but ineligible for Medicaid due to citizenship or Social Security Number requirements.
- Have an emergent qualifying medical condition as described in WACs 388-438-0115, 388-438-0120, or 388-438-0125; AND
- Be approved by the Health Care Authority's (HCA's) medical consultants as meeting the definition of emergency medical condition in chapter 182-500 WAC.

The WAC descriptions below summarize the three qualifying emergent medical conditions:

- 388-438-0115 Alien Emergency Medical (AEM) – The service must be provided in a hospital setting (inpatient, outpatient surgery, emergency room) that includes evaluation and management visits by a physician. Services are limited to those needed to treat the emergency condition. Certification is limited to the month in which the hospitalization occurred.
- 388-438-0120 Alien Medical for Dialysis and Cancer Treatment (AMDCT) – Services under AMDCT are limited to treatment for the qualifying condition of cancer, acute renal failure, end stage renal disease, or anti-rejection medication. These services are not limited to a hospital setting.
- 388-438-0125 Alien Nursing Facility Program – Must meet all other eligibility factors for nursing home placement AND have prior approval authorization by ADSA. This program is subject to caseload limits.

Income and resource limits are the same as for the program to which they are related, i.e., CN or MN scope of care programs for the categories listed in the first bullet on this page.

Eligibility for the AMP is determined by the Specialized Medical Unit (SMU) in the Department of Social and Health Services (DSHS):

SMU Contact Information:

DSHS
CSD – Customer Service Center
PO Box 11699
Tacoma, WA 98411-9905
Toll Free (877) 501-2233

SSI-Related Programs

SSI-related persons include those who:

- Are 65 years old or older (aged), or
- Meet the Social Security Administration's (SSA) definition of blind, or
- Meet the SSA definition of persons with disabilities.

They may be eligible for Categorically Needy (CN) (S02) medical benefits if their income and resources are the same or lower than the standards for SSI.

Effective since January 1, 2012

Number of Persons	Income Limit	Resource Limit
1	$698	$2,000
2	$1,048	$3,000

People with income and/or resources above the standards may be eligible for an SSI related **Medically Needy (MN) (S95, S99)**.

SSI-eligible clients (S01) are those who receive federal cash benefits under the Supplemental Security Income (SSI) program. They receive CN medical coverage automatically. SSA administers the SSI program. The SSI income standard is the Federal Benefit Rate (FBR).

Effective since January 1, 2012

Number of Persons	Income Limit	Resource Limit
1	$698	$2,000
2	$1,048	$3,000

Healthcare for Workers with Disabilities

Healthcare for Workers with Disabilities (HWD) (S08):

HWD is an SSI-related CN medical program that recognizes the employment potential of people with disabilities. Under HWD, people with disabilities (aged 16 through 64) can earn more money and purchase healthcare coverage for an amount based on a sliding income scale.

HWD has no asset test and the net income limit is based on 220 percent of the Federal Poverty Level (FPL)

Effective since January 1, 2012

Number of Persons	Income Limit - 220% FPL
1	$2,049
2	$2,775

To be eligible, a person must meet federal disability requirements, be employed (including self-employment) full or part time, and pay the monthly premium.

Cost of enrollment:

To receive HWD benefits, enrollees pay a monthly premium determined from a percentage of their income. The premium will never exceed 7.5% of total income, and may be less. American Indians and Alaska Natives are exempt from paying premiums for HWD.

Long-Term Care (LTC) and Hospice

LONG-TERM CARE (LTC), Community Options Program Entry System (COPES) (L21, l22), New Freedom (L21, L22), four Division of Developmental Disabilities (DDD) Waivers (L21, L22), Program of all-inclusive care for the elderly (PACE) (L21, L22),

Hospice (L21, L22, L95, L99), Family LTC (K01, K95, K99), Medically Needy Residential and In-home Waivers (MNRW (G03, G95, G99), MNIW (S95, S99),

Nursing Facility LTC – (L01, L02, L95, L99):

The federally matched LTC programs fit individual needs and situations. Home and Community Based (HCB) Services such as COPES and DDD waivers, enable people to continue living in their homes with assistance to meet their physical, medical, and social needs. When these needs can't be met at home, care in a residential or nursing facility is available.

Income limits for LTC programs vary depending on the services needed, living situation, and client marital status. Most clients must pay a portion of their income toward the cost of LTC services, called "participation". Income may be allocated to a spouse and any dependents in the home. A client living at home keeps some income for home maintenance and personal needs. Clients who reside in nursing or residential facilities (adult family homes, group homes and assisted living facilities) keep a small personal needs allowance (PNA) for clothing and incidental expenses. They also pay a set amount toward the cost of their room and board. The amount of income that remains after deductions for personal needs, room and board, allocations, health insurance premiums and any other allowable deductions is the client's participation amount.

Effective April 1, 2012

Institutional Standards	Income Limit
Medicaid SIL	$2,094
Aged, Blind Disabled Assistance Program	$41.62
All other PNA in Medical Institutions	$57.28
PNA state veterans home	$160
PNA single vet or Widow – Improved Pension in Medical Institution	$90
DDD & MPC PNA in ALF	$62.79
COPES maintenance w/o community spouse	$931
COPES maintenance with community spouse	$698
COPES maintenance in ALF	$698
COPES room and board in ALF	$635.21
Housing maximum	$931
Community spouse maintenance	$2,841
Community spouse income and family allocation	$1,839
Community spouse excess shelter allowance	$552
Utility standard	$394
Spousal resource maximum Spousal share exception up to	$48,639 $113.640
Statewide monthly private nursing home rate	$7,474
Statewide daily private nursing home rate	$246

LTC resource limits also vary, depending on specific factors (such as marital status). All resources of both spouses are considered together. Certain resources are excluded (not counted toward the resource limits), such as household goods, personal effects, a car, home equity (up to a set limit) and life insurance with a face value of $1,500 or less. Most burial plots, prepaid revocable burial plans not exceeding $1,500, and irrevocable burial plans, are also excluded.

A Community Spouse (CS) keeps resources according to spousal impoverishment legislation. The Institutional Spouse (IS) keeps the same resources indicated in the table for the Aged, Blind, and Persons with Disabilities.

A different income standard is used to determine eligibility for Categorically Needy (CN) or Medically Needy (MN) LTC services coverage. The standard is 300 percent of the Federal Benefit Rate (FBR), called the Special Income Level (SIL). Gross income at or below the SIL allows approval of CN eligibility for either NF or HCB services. If income is above the SIL, MN eligibility with a spenddown may be considered for NF services or one of the MN HCB waivers. Different rules are used to determine eligibility and participation when both spouses receive LTC services. The local Home and Community Services (HCS) worker can provide this information as needed.

Medicare Savings Programs

Medicare premiums for certain clients who are aged, blind, or with disabilities may be paid for by the Medicare Savings Programs (MSP). MSP has higher income and resource limits than other programs.

Qualified Medicare Benficiary (QMB, S03):

The client must be entitled to, or enrolled in, Medicare Part A. Income must be at or below 100 percent of the Federal Poverty Level (FPL). QMB pays for Medicare Part A premiums if not free, and Medicare Part B premiums, deductibles, and co-payments.

Specified Low-Income Medicare Beneficiary (SLMB, S05):

The client must be entitled to, or enrolled in, Medicare Part A. Income must be between 100 percent FPL and 120 percent FPL. SLMB pays the client's Medicare Part B premium only.

Qualified Individual (QI-1, S06):

The client must have applied for, or enrolled in, Medicare Part B and not be eligible for any other Medicaid coverage. This income group is between 120 percent and 135 percent FPL. QI-1 pays the client's Medicare Part B premium only. If a QI-1 client becomes eligible for Medicaid coverage, the QI-1 program will be closed.

Qualified Disabled Working Individual (QDWI, S04):

The client must:

- Be entitled to or enrolled in Medicare Part A
- Be a working person with disabilities
- Have exhausted premium-free Part A
- Have lost SSA disability benefits because of earnings over SSA's gainful activity limits

The income limit is 200 percent the FPL. QDWI pays the client's Medicare Part A premium only. Individuals considering this program may also benefit from information about the Healthcare for Workers with Disabilities program.

Effective April 1, 2012

Medicare Savings Program	Federal Poverty Level (FPL)	Monthly Income Limit – One Person	Monthly Income Limit - Two Persons
QMB	100%	$931	$1,251
SLMB	120%	$1,117	$1,513
QI-1	135%	$1,257	$1,703
QDWI	200%	$1862	$2,502
QMB,SLMB, QI-1 Resources	N/A	$6,940	$10,410
QDWI Resources	N/A	$4,000	$6,000

Medically Needy (MN) and Spenddown

Medically Needy (all letter codes with 95 or 99 after the letter):

Medically Needy (MN) is a federal- and state-funded Medicaid program for persons who are aged, blind, have disabilities, pregnant women, or children, with income above Categorically Needy (CN) limits. MN provides slightly less medical coverage than CN, and requires greater financial participation by the client.

MN clients with income above MN limits are required to spend down excess income before medical benefits are authorized. The client spends down the excess by incurring financial obligations for medical expenses equal to the spenddown amount. The client is responsible for paying these medical expenses.

Effective since January 1, 2012

Number of Persons	Income Limit - 220% FPL
1	$698
2	$698
3	$698
4	$742
5	$858
6	$975
7	$1,125
8	$1,242
9	$1,358
10 or more	$1,483

Spendown:

Spenddown is like an insurance deductible. It's the process used to determine the client's liability for the cost of medical care. Clients must incur medical expenses equal to their excess income (spenddown, or liability) before medical benefits are authorized. The spenddown liability is the client's financial obligation and can't be paid by the state. The State computes the amount of the client's spenddown using a base period, consisting of three or six consecutive calendar months. Depending on when the client's incurred medical expenses meet the spenddown liability, the client may get medical benefits for all or part of the base period.

Spendown Example:

Applicant is a single woman, age 67. She receives $820 Social Security benefits each month and has $1,000 in savings. The client's $1,000 resources are below the resource limit of $2,000, so she is resource eligible. Her income is above MN income limits, but MN allows spenddown of excess income. She is eligible for MN when she meets spenddown.

SSA benefits (less $20 general disregard* $820 – $20)	$800
Less MN income limit	– $698
Excess income	= $102

The client can choose between a three-month or a six-month base period – whichever is better for her, considering her spenddown amount and the cost of medical bills she expects during the period. She will have to incur either $306 ($102 times 3 months) or $612 ($102 times 6 months) in medical expenses before she is eligible for MN. This is her spenddown amount. She will be responsible for these expenses; Medicaid will pay for her covered medical expenses after she meets spenddown.

** General Disregard: The federal government allows $20 of the client's unearned income as a disregard when determining income limits.*

Medical Care Services

Medical Care Services (MCS) is the state-funded medical program that provides limited medical benefits to incapacitated eligible adults and to those eligible for the Alcohol and Drug Addiction and Treatment and Support Act program (ADATSA). Incapacitated adults are persons between 18 and 65, who are unable to work due for physical or mental reasons that are expected to last less than 12 months. Income and resource limits are more restrictive than for the family CN medical program. A person eligible for MCS must have countable income less than $339 per month and must have less than $1000 in countable resources. MCS does not cover out-of-state medical care.

ADATSA

Alcohol and Drug Treatment (ADATSA, GA-W, W01, W02, W03):

ADATSA is the state-funded program that provides shelter and/or medical benefits, treatment, and support under the Alcohol and Drug Addiction Treatment and Support Act for persons incapacitated from gainful employment due to drug or alcohol abuse. Limited medical benefits are provided under Medical Care Services (MCS).
The DSHS Division of Behavioral Health and Recovery (DBHR) administers ADATSA.

For persons waiting to get into treatment, medical care only is available through this program.

Washington Recovery Helpline 1-866-789-1511

Useful Web Addresses:

DSHS Division of Behavioral Health and Recovery (DBHR) ..... **http://www.dshs.wa.gov/DBHR/**

DBHR Problem Gambling Program ..... **http://www.dshs.wa.gov/dbhr/gambling.shtml**

The ABC's of ADATSA ..... **http://www.dshs.wa.gov/pdf/dbhr/da/ABCsofADATSA.pdf**

Psychiatric Indigent Inpatient Program (PII)

The PII (M99) program ensures eligible clients receive continued psychiatric inpatient hospital services. The program funds voluntary community psychiatric inpatient hospital care for indigent clients who qualify.

Important: The maximum length of certification for PII is three months in any 12-month period.

Income and resource limits for the PII program are the same as for the Medically Needy (MN) program. Clients with excess income or resources above the MN limits must spend down the excess before they are eligible for PII.

The PII program pays only for emergent inpatient psychiatric care in community hospitals within the state of Washington. PII doesn't cover ancillary charges for physician, transportation, pharmacy or other costs associated with a voluntary inpatient psychiatric hospitalization. The Division of Behavioral Health and Recovery (DBHR) administers the PII program.

Emergency Medical Expense Requirement (EMER): PII requires $2,000 EMER per family for each continuous 12-month period before a family member can be eligible for the program. The EMER is comparable to a deductible on an insurance policy. An applicant can meet this requirement with voluntary inpatient psychiatric hospitalization only.

Involuntary psychiatric hospitalizations (commitments) are authorized under the Involuntary Treatment Act (ITA), RCW 71.05 and RCW 71.34. Generally, there is no change in how ITA cases are handled. For those who are not eligible for medical assistance, hospitals continue to use existing procedures to bill ITA cases. That process is separate and apart from the Psychiatric Indigent Inpatient (PII) program.

Client Services Card

The Client Services Card (Services Card) is a permanent plastic card issued to each person who receives medical benefits through the Health Care Authority (HCA) programs. Clients keep these cards and use them whenever they are eligible for medical benefits. The card doesn't guarantee eligibility for any specific time, but providers can use the card to determine if the client is eligible for medical benefits at the time of service.

Front

Back

Covered Services

The Health Care Authority (HCA) provides a wide range of medical services. Not all eligibility groups receive all services.

Coverage is broadest under the Categorically Needy (CN) program.

Scope of Healthcare Services Table

Note: The level of medical coverage for any given client depends on the medical assistance Benefit Service Package for which the client is eligible. This table lists services that may be provided under the specific services/programs if the individual meets all the criteria required to receive the service. Some services may require prior authorization from HCA or a contracted managed care plan. This table is provided for general information only and does not in any way guarantee that any service will actually be covered. Benefits, coverage, and interpretation of benefits and coverage may change at any time. Coverage limitations can be found in federal statutes & regulations, state statutes & regulations, state budget provisions, and HCA Medicaid Provider Guides, and Provider Notices. Clients with questions regarding coverage may call the 800 number on the back of their Services Card.

Service Categories	CN[1]	21+	MN 20-	21+	MCS
Adult day health	Y	Y	Y[2]	N	N
Ambulance (ground/air)	Y	Y	Y	Y	Y
Blood	Y	Y	Y	Y	Y
Dental services	Y	N	Y	N	N
Detoxification	Y	Y	Y	Y	Y
Diagnostic services (lab and X ray)	Y	Y	Y	Y	Y
Health care professional services	Y	Y	Y	Y	Y
Hearing evaluations	Y	Y	Y	Y	Y
Hearing aids	Y	N	Y	N	N
Home health services	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y
Hospital services – inpatient/outpatient	Y	Y	Y	Y	Y
Intermediate care facilities for the mentally retarded	Y	Y	Y	Y	Y
Maternity care & delivery	Y	Y	Y	Y	N
Medical equipment, durable (DME)	Y	Y	Y	Y	Y
Medical equipment, nondurable (MSE)	Y	Y	Y	Y	Y

(continued on next page)

Service Categories	CN[1]	21+	MN 20-	21+	MCS
Medical nutrition services	Y	Y	Y	Y	Y
Mental health services:	Y	Y	R[5]	N	N
• Inpatient care	Y	Y	Y	Y	Y
• Outpatient community mental health services	Y	Y	Y	Y	Y[3]
• Psychiatrist visits	Y	Y	Y	Y	Y[4]
• Medication management	Y	Y	Y	Y	Y
Nursing facility services	Y	Y	Y	Y	Y
Organ transplants	Y	Y	Y	Y	Y
Out-of-state services (excludes border cities)	Y	Y	Y	Y	N
Oxygen/respiratory services	Y	Y	Y	Y	Y
Personal care services	Y	Y	N	N	N
Prescription drugs	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	N
Prosthetic/Orthotic devices	Y	Y	Y	Y	Y
Psychological Evaluations[5]	Y	Y	Y	Y	N
Reproductive health services (includes family planning and TAKE CHARGE)	Y	Y	Y	Y	Y
Substance abuse services	Y	Y	Y	Y	Y
Therapy – occupational, physical and speech	Y	Y	Y	Y	Y
Vision care - Exams, refractions, and fittings	Y	Y	Y	Y	Y
Vision - Frames and lenses	Y	N	Y	N	N

LEGEND: Y=Yes, service is usually included**; N=**No, service is usually not included

[1] Clients enrolled in the Children's Health Insurance Program and the Apple Health for Kids program receive CN-scope of medical care.

[2] Restricted to 18-20 year olds.

[3] Restricted to ABD, PWA, and MCS clients enrolled in managed care.

[4] MCS clients can receive one psychiatric diagnostic evaluation per year and eleven monthly visits per year for medication management.

[5] Only two allowed per lifetime.

*** Medicare recipients receive outpatient prescriptions through their Medicare Part D plan.**

Other Services

- **Alien Medical Program (AMP)**
  HCA covers only those services necessary to treat the client's emergency medical condition.

- **Non-Emergency Medical Transportation (Brokered Transport)**
  HCA covers non-emergency medical transportation for eligible clients to or from covered services through contracted brokers. The brokers arrange and pay for trips for qualifying clients. Currently, eligible clients include: Medicaid, CHIP, CHP, MCS, ADATSA, and AEM recipients.

- **Interpreter Services -- Sign Language**
  HCA covers the cost of sign language services for eligible clients. Sign language interpreter services must be requested by Medicaid providers, HCA staff or HCA-authorized DSHS staff, and must be provided by HCA approved contractors.

- **Interpreter Services -- Spoken language**
  HCA covers interpreter service for eligible clients through contracted brokers. Requests for spoken language interpreter services must be submitted by Medicaid providers, HCA staff, or HCA-authorized DSHS staff.

- **Psychiatric Indigent Inpatient (PII) Program**
  HCA covers voluntary psychiatric inpatient care for clients eligible under the PII program.

- **QMB-Medicare Only**
  HCA covers only the Medicare coinsurance and deductible up to the Medicare or HCA allowed amount, whichever is less.

Customer Service Information

Clients and providers may both call 800-562-3022 for more information.

- Providers can contact Medicaid by e-mail by filling out on-line forms at **https://fortress.wa.gov/dshs/p1contactus/Default.aspx**
- Clients should include an ACES number or Services Card number for identification and faster service.

Locate HCA Billing Instructions at **http://hrsa.dshs.wa.gov/download/bi.html**

Acronyms

ADATSA = Alcohol and Drug Abuse Treatment and Support Act

CN = Categorically Needy Program

TC/FP = TAKE CHARGE/Family Planning Only

MCS = Medical Care Services

MN = Medically Needy Program

CHIP = Children's Health Insurance Program

WACs dealing with Scope of Care are located at:

Healthcare general coverage:
http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0050

Healthcare coverage - Scope of covered categories of service:
http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0060

Healthcare coverage - Description of covered categories of service:
http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0065

Customer Toll-Free Numbers

Aging & Disability Services 1-800-422-3263

Basic Health Plan 1-800-826-2444

Fraud Hotline number when you suspect someone (client or provider) is committing fraud concerning DSHS cash, medical, or food benefits 1-800-562-6906

Medical Assistance Customer Service Center (MACSC) for Clients ..... 1-800-562-3022, Option 1, 6
7:30 am-5 pm, Monday through Friday
TYY/TDD users only 1-800-848-5429
To order large print or Braille ..... 1-800-562-3022, Option 1, 6, 2

Medical Eligibility Determination Services (MEDS) ..... 1-800-562-3022 (ext. 16136)

TYY/TDD users only 1-800-833-6388

Pharmacy Authorization ..... 1-800-562-3022, Option 1, 5, 2

Provider Enrollment ..... 1-800-562-3022, Option 1, 5, 7
7 am-4 pm Monday, 7 am-1 pm Tuesday-Friday,

Provider Inquiry 1-800-562-3022

Third Party Resource Hotline (Coordination of Benefits) 1-800-562-3022

Washington Recovery Helpline 1-866-789-1511

Useful Web Addresses

DSHS Division of Alcohol and Substance Abuse/
Division of Behavioral Health and Recovery ..... **http://www.dshs.wa.gov/DBHR/**

Basic Health Plan ..... **http://www.basichealth.hca.wa.gov/**

Economic Services
To apply for assistance on-line ..... **http://www.washingtonconnection.org/home/**
To locate your Community Services Office ..... **http://www.dshs.wa.gov/onlinecso/findservice.shtml**

Eligibility A-Z Manual ..... **http://www.dshs.wa.gov/manuals/index.shtml**

HCA and DSHS Rules
Washington Administrative Code ..... **http://apps.leg.wa.gov/wac/**

Medicaid Billing Instructions ..... **http://hrsa.dshs.wa.gov/Download/BI.html**

Medicaid Intranet ..... **http://sharepoint.dis.wa.gov/insidehca/default.aspx**

Medicaid Numbered Memos ..... **http://hrsa.dshs.wa.gov/download/Numberedmemos.html**

ProviderOne Information ..... **http://hrsa.dshs.wa.gov/providerone/**

Washington State Law (RCW's) ..... **http://apps.leg.wa.gov/rcw/**

Washington State
Health Care Authority

HCA 22-315 (6/12)